DEPARTMENT OF PUBLIC HEALTH NURSING
UNIVERSITY OF TORONTO

Vol. XIX. No. 2

THE CANADIAN NURSE

AND HOSPITAL REVIEW

Owned and Published Monthly by the Canadian National Association of Trained Nurses

PRINTED BY EVANS & HASTINGS, VANCOUVER, B. C.
Registered at Ottawa, Canada, as Second-Class Matter

FEBRUARY, 1923

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All Communications to be addressed to the Editor and Business Manager, Vancouver Block, Vancouver, B. C.

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VOL. XIX. VANCOUVER, B. C., FEBRUARY, 1923 NO. 2

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Blood Transfusion

By CHARLES K. P. HENRY, F.A.C.S., MONTREAL.

An Englishman in 1665 first successfully transfused animals, and the account of a dinner party given by Lord Penn, as described in Pepy's Diary, when the story of the dogs who ran about after transfusion was treated with derision, exemplifies the usual reception of new procedures.

In 1667 a Frenchman, Denys, transfused a man, using sheep's blood, and the patient was greatly benefited. From then till in Baltimore in 1910-1912, when Moss established the presence of the four blood groups in man, there was no safe basis for the transfusion of human blood. In the intervening two centuries and a-half the story of transfusion is easily told. Fatalities were so numerous that governments passed laws to prohibit its practice, and it fell into discredit.

Babies, up to three weeks old, may be transfused from either parent, though occasionally trouble may result here. From that age up to

six months, sometimes later, all fall into their proper blood group. These groups depend on the reaction of the fluid portion of the blood—the plasma or serum, and the cells or blood corpuscles on the similar elements of the blood of the donor whose blood is injected into the patient. Blood may safely be given from one person in a group to any one in the same group. Nature, fortunately, has even simplified this by giving us one group, number IV., which is about 42 per cent. of all people, whose blood safely mixes with that of individuals in the same or in any of the other groups. Such a group IV. person is called a "universal donor".

Therefore an essential preliminary to transfusion is to test the patient and donors till matched ones are secured. The donor must be free of disease and have a negative Wassermann. Age, sex, race and relationship have no importance. I have used donors in their teens and old folks over sixty. I have transfused babies and old people of over seventy-five years. Any hospital laboratory, or any doctor, can readily carry out these tests, as simple methods are recorded in the recent literature.

Transfusion is not a "cure-all", and yet the indications for its use and the benefits obtainable are referable to so many conditions now that its field of usefulness is daily widening.

Leisrink's statement, in 1876, still holds good, nearly fifty years later: "Transfusion is indicated in all those pathological conditions when the blood in quantity or quality is so altered that it is unfit to fulfil its physiological duties."

Where the quantity is depleted by haemorrhage, either due to traumatism, as railroad accidents for example, or to haemorrhage from disease, as gastric ulcer haemorrhage—nothing in surgery is more spectacular than the prompt return to well-being after a transfusion. In October, 1920, a man was wheeled into the Montreal General Hospital operating room, preceded by an interne's statement that it was useless to collect the blood from the donor, as the patient was practically dead. A rapid transfusion of well over a pint of blood from a hospital orderly in group IV. resulted in the patient's arousing from his coma, looking at the members of the clinic, and speaking before he left the operating room twenty minutes later. He afterwards recovered and left the Hospital walking.

The recent war proved the efficacy of transfusion for traumatic haemorrhage, and thousands of lives could have been saved if its use had been possible everywhere at the Front.

In private and hospital practice we find its use extending in conditions where the *blood quality* is deficient. This may be due to blood diseases, as purpura, pernicious anæmia, or to deficiency in one or more constituents in the blood. In jaundice of long standing, operation is often followed by fatal haemorrhage because of deficient blood clotting. In haemophilia, that hereditary blood disease of defect in blood clotting, transfusion will often prove life-saving. In such conditions and in secondary anaemias due to chronic sepsis, long continued fevers, as typhoid, prolonged post-partum

septicaemia, transfusion frequently ensures a quick convalescence and promptly terminates the infection. Early in 1922 a woman post-partum about 66 days, with one or more rigors daily, with a range of temperature of from 96 to 106 degrees and over, sweating, œdema of extremities, marked anaemia and all its train of symptoms, was transfused by the writer in her own bed at home, using as a donor a willing husband. She had only one chill after, her temperature never again reached 105 degrees, declined rapidly and in one week reached normal, and she made a good recovery. A similar case at the Montreal Maternity Hospital, after a four to six weeks' illness, reached normal in a few days. But the fulminating cases of puerperal septicaemia, or rather surgical septicaemia, are not benefited by transfusion in the acute stage.

The following synopsis will give most of the conditions in which transfusion is indicated, has been practised, and is of value in the author's experience. In 200 transfusions most of these conditions have been dealt with.

INDICATIONS FOR TRANSFUSION

1. *To replace loss of blood.*
   - (b) Post haemorrhagic anaemias. bleeding due to—
     - 1 traumatism.
     - 2 gastric, duodenal ulcers.
     - 3 typhoid ulcers.
     - 4 pregnancy and complications—
       (abortion, placenta praevia, post partum haemorrhage, ectopic gestation, rupture of uterus.)
     - 5 haemorrhoids, etc.
   - (b) Blood diseases—
     - 1 pernicious anaemia.
     - 2 splenic anaemia.
     - 3 purpura haemorrhagica.
     - 4 haemophilia.
     - 5 leukaemia.
     - 6 haemolytic jaundice.
   - (c) Secondary anaemias due to—
     - 1 chronic sepsis—surgical, obstetrical, etc.
     - 2 chlorosis.
     - 3 results of continued small haemorrhages, epistaxis, etc.
2. *To replace defective blood constituents.*
   - 1 haemophilia.
   - 2 purpura.
   - 3 jaundice, preparatory to, or after operation.
3. *Conditions of toxaemia or malnutrition.*
   - 1 toxaemia of burns.
   - 2 coal gas poisoning.
   - 3 eclampsia.
   - 4 infantile malnutrition.

The Results of Transfusion.

The results of transfusion are, (1) immediate, (2) delayed.

1. Immediate. Immediate results are seen on the table in the rapid improvement of facial colour, the filling and rendering visible of capillaries in the face, nails, conjunctivae and elsewhere. The rapid pulse, fast respiration slow down, the "air hunger" is relieved, and the restless, irritable, often irrational patient becomes quiet, calm, and the mental processes clearer. One young girl about to be transfused could not remember the name of her brother lying by her side as prospective donor. Another woman believed she was to be burned in the furnace when taken from her private ward to the operating room! Both cases showed immediate marked mental clarity following the transfusion. With the increased blood supply to the brain the memory clears, the eyesight and hearing brighten, and taste and smell are improved. The appetite is improved, thirst is lessened and the anaemic headache disappears at once, or during the first few hours. A blood count shows an immediate improvement of from 10 to 35 per cent. in haemoglobin, the red cell count goes up one-half to one million cells.

2. Delayed. Delayed results are shown by increased muscular tone and strength, gain of weight, cessation of haemorrhage and marked improvement in successive blood counts.

Ill results are few. At worst a chill and rigor with temperature to 106° may ensue, sometimes with headache and vomiting. This occurs in the first one to three hours, though sometimes a reaction is delayed till the next day. In twenty successive cases taken from my records, beginning January 1, 1922, we had but two reactions, both in the same patient, who had previously been transfused for pernicious anæmia. In one woman, transfused eleven times, for the same disease, there were eight reactions. The large majority of our reactions occurred in pernicious anæmia cases. They do not lessen the benefits of the operation, and are treated by heat in the cold stage; quiet; stimulants are rarely needed; a hot drink, if there is no vomiting, may be given, and the reaction is usually over in from one to four hours. Mild reactions of nausea, chilliness only, temperature up to 100 degrees, occur about four times to one of a severe reaction. In 200 cases our reactions do not exceed 20 per cent., most of them slight, many of them not being appreciated by the patient at all and recorded only by the slight rise of temperature. In none was there any danger to the patient, or ill effects noted after the reaction passed over.

Methods of Transfusion.

The methods of transfusion are numerous, some simple and some complicated, but all are devised with the intention of preventing clotting of the blood taken from the donor before it is introduced within the patient's veins. In this article the method used by the author is illustrated and has been used with satisfaction since December, 1917, in 200 cases

done by him, and in numerous additional cases by other operators in the Montreal General Hospital.

The collection of the blood is by a large-sized needle introduced against the venous blood stream and the blood flows into the vessel containing 2 per cent. sodium citrate solution in the proportion of 30 c.c. to each 220 c.c. of blood collected. This prevents clotting.

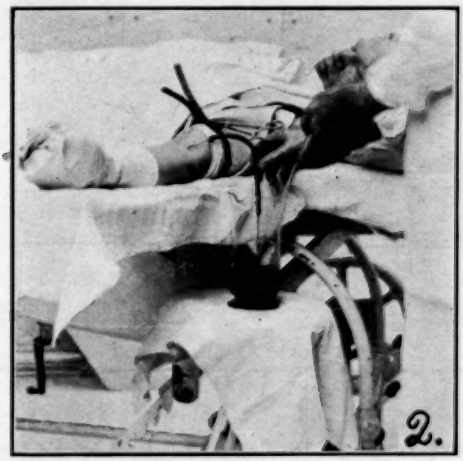

Fig. 2.—Collecting the blood, note blood flowing from end of tubing.

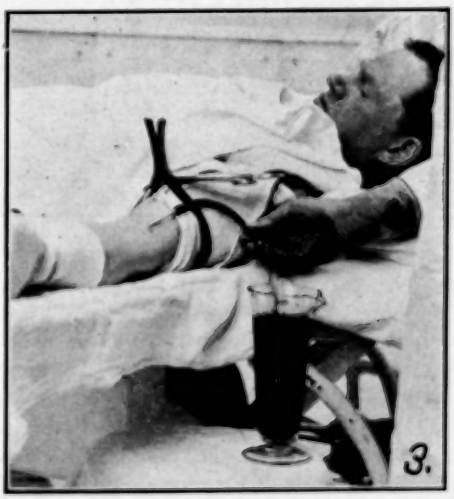

Fig. 3.—500 c.c. blood collected, tube pinched shut by operator.

It is then run into the patient's vein by means of any infusion apparatus.

Fig. 4.—Infusion into Patient.

The whole outfit is simple and cheap. It can be sterilized and kept ready for use.

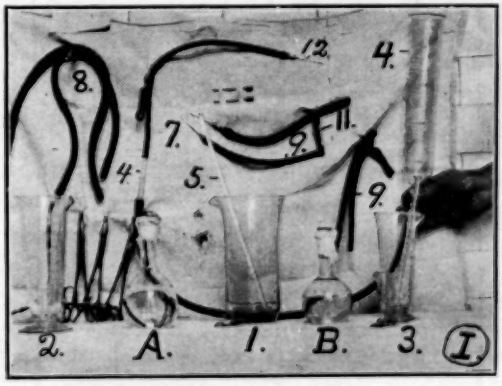

Fig. 1.—Transfusion Set.

We have two such outfits in the Hospital, and on many occasions I have done two or more transfusions in one day. The donor does not need to be in the same room as the patient, who can be transfused at his own home in his own bed; or the blood can be collected and taken miles away to the patient, kept warm in a Thermos bottle, previously sterilized.

There is no necessity for dissecting out a vein, no chances of infection to donor or patient, and the method requires one assistant, not necessarily a doctor or even a graduate nurse. Several times in the country or in private homes I have used an assistant who had never previously seen a transfusion. With a safe method, a previous selection of a suitable donor by proper blood tests, the operation of blood transfusion offers for certain conditions the only cure, in others the best treatment,

and in many others a treatment that is worthy always of consideration and often of a trial.

References: (1) I. Maclaren Thompson, *Canadian Medical Association Journal,* October, 1921; (2) Norman Guiou, *Canadian Medical Association Journal,* July, 1922; (3) Chas. K. P. Henry, *Canadian Medical Association Journal,* January, 1917; (4) Chas. K. P. Henry, *Canadian Medical Association Journal,* February, 1920; (5) Chas. K. P. Henry, *Canadian Medical Association Journal,* January, 1922; (6) A. H. Sanford, *The Journal Lancet,* November, 1917.

NEVER THROW OUT MEDICINES

Destroy all unmarked medicines, whether liquid or powder. Oxalic acid, a deadly poison, closely resembles Epsom salts. Many powders look identical. You cannot be too careful to label everything, legibly and indelibly.

Never throw out medicines. Destroy them past all danger of their harming children or animals. Every one of us can probably call to mind so many tragedies resulting from violation of this rule, in which children have taken deadly drugs found in waste basket, ash can, or rubbish pile, that it is scarcely necessary to point out the reason for the caution, while many household pets have come to untimely ends in the same way.—CLARA D. NOYES, R.N., in *The Health Builder* for November.

ARTIFICIAL TEETH

We referred recently to the defective cleaning of tooth plates pointed out by Dr. Grange in a medical journal; another writer supports him and adds:—A denture should be removed and brushed preferably after each meal, always after breakfast and at night; the gum covered by the plate, and so deprived of the natural friction of the tongue, and especially the gum margins round remaining teeth, should also be vigorously brushed. Before retiring the denture should be scrubbed with a stiff brush, dipped in water (preferably with a lump of soda added), rubbed on a piece of soap, and then charged with powder or paste. Special care should be given to the inside of clasps fitting round natural teeth, for which a pointed piece of cane should be used instead of a brush.

During the night the denture should be left in water to which some antiseptic has been added. For this purpose a chlorine preparation is suitable, for, though the taste is unpleasant, its effect, especially on gold, is almost magical, and greatly diminishes the trouble of brushing.

From Dr. D'Oyly Grange's statement, that it is sometimes necessary to wear dentures at night, I must differ emphatically and have yet to see the case where it is so. I regard it as a most pernicious practice.

—*Nursing Mirror.*

Dying Statements

Trouble having arisen on more than one occasion between the Crown officers of Toronto and the authorities of the Toronto General Hospital, because of alleged negligence on the part of the latter to convey to the former information made by certain dying patients who had met with foul play or maltreatment, Hon. Justice W. R. Riddell was asked by the Attorney-General to preside over an informal but representative committee to consider the proper practice in cases of apparent crime.

Inter alia it was agreed that it would be of advantage that a simple and practical statement as to "dying declarations," "ante mortem statements" or "evidentiary declarations" should be prepared for the guidance of medical men generally and those in hospitals particularly.

In respect to declarations as evidence, Judge Riddell states that the general rule of our law is that only what is said under the sanction of an oath (or its legal equivalent) can be received as evidence. But for about two hundred years the English law, which our law follows, has made an exception in what have been called "dying declarations," or "ante mortem statements"—sometimes "evidentiary declarations."

General Remarks

When a judicial investigation is being made into the death of any person by homicide, statements made by that person respecting the circumstances resulting in his death are admitted in evidence, if such statements are made by him when under the influence of a conviction that his death is impending.

Sometimes such evidence is of the very greatest importance, since frequently no third person was present. It is, of course, the duty of every good citizen to disclose crime and to preserve evidence of it. A medical man, therefore, attending a patient likely to die under circumstances indicating a crime by act of omission or commission which directly or indirectly caused his death, should endeavor to obtain such evidence from him as is available; and this sometimes is as useful to protect the innocent accused of crime as it (more frequently) is to convict the guilty.

This is not (as it is sometimes offensively put) to act the part of a detective, but to act the part of a good citizen, and it is called for only in cases of apparent homicide where there is reason to suspect that the condition of the patient is due directly or indirectly to crime, foul play or criminal negligence.

Speaking generally, it is always wise for the doctor, as soon as he thinks that a case is hopeless, to inform the patient of the fact—he may have affairs to settle, a will to make, directions to give, etc.

Difficulties may sometimes arise as to which it is impossible to lay

down any fixed rule—for example, the patient may be of such a temperament that a statement of this kind would probably cause death sooner than it otherwise would occur, etc. Medical men are always conscious that (speaking generally) their first duty is to the patient, and that consequently nothing which can be reasonably and properly avoided should be done which is likely to harm the patient; and yet, exceptional cases may occur in which the private must give way to the public good. The medical man must face the situation, if and when it arises, and determine as his conscience and sense of public duty dictate. Cases of this kind are exceptional; and in no case should fanciful or captious objections be raised; in all cases of *real* difficulty, the Crown Attorney should be at once consulted.

Rules of Law

To make a declaration evidence, there must be in the mind of the patient an impression of impending death—if he believes that his case is hopeless, but that there will be a prolonged continuance of life, a declaration is not admissible. There must be an expectation, a hopeless expectation, of death near approaching. It is of no importance that the physician, or any other than the patient, thinks he may recover—the important thing is the expectation of the patient. Nor is it of any importance how this expectation is induced, whether from the patient's own observations, statements of medical men or otherwise — the essential matter is its existence, however induced.

This expectation, impression and conviction that death is impending may be manifested by the patient in any of several ways—he may say so in so many words, or he may indicate his conviction of impending death by changing countenance and appearing distressed or terrified when he is informed of it, etc. He may do this without any words of apprehension, and still make his conviction clear.

It is of great importance for the ends of justice that the attending physician should not only make the state of the patient unmistakably clear to him, but also that he should, if possible, obtain unmistakable evidence that the patient was convinced and without hope.

Direction for Taking Evidence

Where there is ample time, the police and Crown authorities may be communicated with to take the declaration; but no chances should be taken whereby the evidence may be lost.

The doctor should satisfy himself that the patient understands what is said to and by him.

The declaration may be elicited by questions put to the patient.

Everything said by him in respect of the circumstances causing death should be noted, even if it may seem to be immaterial.

It is very desirable that the declaration be reduced to writing; where circumstances permit, it should be read over to the patient; and if he is

able he should be got to sign it; witnesses present should also sign as witnesses. Magistrates sometimes examine a patient on oath and the examination is signed by both—this is permissible.

It is, however, not absolutely necessary that the declaration be reduced to writing at all. If circumstances do not permit of a written declaration, an oral declaration should be obtained. In that case, all present should take full notes of what is said, so that the memory may be refreshed (if necessary) when evidence is to be given of the declaration. (Such notes are, however, not evidence in themselves.)

If the declaration be reduced to writing and circumstances prevent its being signed by the patient, the witnesses should sign it after making certain that it is accurate—the absence of the signature of witnesses is not fatal to the declaration, but such signature is always advisable.

Practical Rules

1. A declaration is admissible in evidence only concerning the circumstances resulting directly or indirectly in the death of the patient himself.

2. It must be made under the influence of a conviction in the mind of the patient that his death is impending.

3. It may be made to anyone.

4. The doctor should not imperil the obtaining of such declaration by waiting for the police or Crown authorities.

5. Where there is ample time it is well to communicate with police and Crown authorities.

6. A declaration may be obtained by questions; and when the statements of the patients are not full, it is often well to supplement them by information obtained in answer to questions.

7. When possible, the declaration should be reduced to writing, read over to and signed by the patient—if it is also signed by witnesses, this is the ideal declaration.

8. But a written declaration without signature is admissible.

9. And so is an oral declaration.

10. In case of any difficulty at any stage, the Crown officers should be at once consulted.

11. In all cases of doubt the declaration should be taken, leaving it to the court to determine its admissibility and value.

12. Crown and police authorities generally prefer to take the declaration by stenographers. These rules are, however, not intended for the guidance of such authorities, but for medical men or laymen who can seldom obtain stenographic assistance.

All hospital authorities in Canada would do well to keep this article handy, to be read by every house surgeon and head nurse.

—*The Hospital World.*

Inspection of Training Schools in British Columbia

By HELEN RANDAL, R.N.,
Registrar for G. N. A. of B. C.

The title of the paper which I was asked to read here to-night sounds much more formidable than it really is, and the term "inspection" used for want of a better one which would exactly express my interpretation of the visits made to the training schools in our province.

At the time our Act was passed, we hoped that the Legislature would appoint a registered nurse to fill the position of Training School Inspector, with full power to act and to enforce the law. In talking the matter over with several of our law-makers and particularly the head of our Department of Health, we were told that the Legislature had passed our Registered Nurses' Act with its definite statement of what was and what was not an accredited training school; so therefore we were authorized to do our own inspection, supervising and whatever else we wished to do in order to carry out the Act. With this in mind and feeling that we had a real obligation laid upon us to help the schools training nurses, the Graduate Nurses' Association of British Columbia instructed me to visit these schools, make a survey and report.

Every effort was made to get in closer touch with the members of hospital boards, high school officials and students, and with interested people wherever it could be done. The result was satisfactory, more so than was anticipated, and since then a visit has been made yearly to each school.

It may interest you if I tell you in detail something of the plan worked out and its result. I usually write the head of the training school, telling her when I hope to be with her and asking her to notify the hospital board that they may, if they so choose, talk hospital and training school matters over with me. I also ask her if she and the principal of the high school think it would be helpful if I talked to the entrance class and those already in high school about the value of completing their high school course in order to succeed in any line of work they may eventually take up, stressing, of course, the training for nurses, with the large field ready for the competent graduate nurse; and the fatal attitude of too many parents in allowing children to leave school without the high school certificate or matriculation standing. This is usually granted with great willingness, and one is usually thanked by the principal for bringing the old topic they present daily to the child from another angle and from one who is not a teacher. It also opens up a channel of communication between training schools and the high school and a possible arrangement for night or special classes in technical subjects, such as chemistry for the pupil nurse. The girls are good listeners and appear interested in the ten-minute talk, which is my limit.

So much for the outside aspect of the visit. As to meeting the board: I always try to go over the hospital very carefully, check up all points in connection with the school, ask to see records of students, equipment for teaching and demonstrating, and generally talk over the situation with the superintendent of nurses. She, poor woman, generally knows what is lacking, but seems to be unable to get the board to see the real need. Then, when the board have asked me to meet them, I am prepared to show them the best points of their school and hospital, and what must be amended to conform with the Act's standard of an accredited school. Each year there has been a marked desire to get whatever was required in the way of equipment, books, etc., but is far harder to show them that the present way of teaching must change if it is to be a real school—and nothing else will do if they accept young women as pupils. I have found the men and women splendid people, with the deepest interest in the hospital, but with probably less real knowledge of it as an educational institution than could seem possible. One has to remember that to most of them pupils in training schools are, and this idea is deeply fixed, though unconscious, on their part, either the cheapest means of labor obtainable or taken casually as the accepted means of staffing a hospital.

In our Act affiliation has been arranged for and has helped the condition of nurses in training in these smaller hospitals immensely. It may interest you to know that these affiliates have done very well in their examination for R.N. certificates, and they have gone back in several cases to their own schools as staff nurses with a thankful realization of what the third year spent in a large hospital has done for them.

Last year, at the meeting of the B. C. Hospital Association, some members of small hospital boards complained that it was a hardship for their institutions to have this affiliation, not realizing that it is largely due to this attractive feature of the small school prospectus that draws young women to them and the small hospital.

They must face the proposition that whatever the financial situation is, and no matter how sympathetic we may be with their difficulties, the fact remains that they are obligated, when they open a school, to see that everything understood in the word "school" must be provided. Several small schools, and by small schools I mean really small ones of 20 to 30 beds, are now getting students with a two-year high school preliminary education into their training schools when otherwise they would be experiencing the shortage they had before. Certain economic factors might send some young women to them, but the young woman equipped with a proper preliminary education would go elsewhere. This is the only complaint made, the larger hospitals being most generous and careful in their arrangements for these students and for the betterment of their special training.

The full co-operation of the hospital boards would, I am sure, be

with us, if they did not have the financial stress of running a hospital as it is run to-day—on their shoulders—and failing to see that nothing will release them from their responsibility in undertaking a school.

The superintendent of nurses—yes, she is that—is also the instructor, the housekeeper, often the operating-room supervisor, the bookkeeper, and the practical executive officer responsible day and night—stands begging the question when pertinent remarks and queries are made regarding the classes and teaching of theory. "Oh yes," she says, "they have lectures by the doctor." A little sifting down of that statement shows clearly just what that means. As one enlightened president of a small hospital board said to me recently, "We are running our school on charity so far as teaching goes." Lectures are given by a man who in many cases never could teach, no matter how clever he may be professionally, or else he remembers part of his student lectures and endeavors to carry the nurses on far above their heads as if he were addressing medical students. We, the association, endeavored to find out just how real was the request that we put on a travelling teacher to help these schools, and, in answer to our questionnaire, it boiled itself down to this—that if the association was willing to finance the teacher, they would accept her services. This was not our plan, though we did expect to help plan curricula with her, and otherwise assist, but it was not intended to relieve the school from its financial responsibilities. The teaching problem of the small schools is the problem still. It is one of the things that will be taken up by our newly-appointed Nursing Education Standing Committee of our Provincial Association, and we hope to find the solution. Making lesson plans, arranging for institutes or demonstrations to be given at the time of our annual meetings, will, I think, be of inestimable use to these schools.

Registration examinations are arranged for in this province, so that the pupils may take this examination prior to their graduation. This, we hope, is the beginning of one examination for both school and provincial board of R.N. examiners. It takes a little time to bring this about, but the feeling is that it will be a wise and popular step.

One thing this survey has shown is the absence of any attempt on the part of hospital boards to ask for any special qualifications in those whom they choose as members of the staff, and particularly of the all-round woman they confidently expect to find in anyone who applies for the position of superintendent of the hospital and school, with the other duties attached, to which I have made reference. They seem to think that the mere fact of holding a diploma from any school and applying for the position is enough to guarantee what they want being forthcoming. One of our hopes, perhaps I had better say dreams, is that we may soon establish a confidential bureau for both hospital and executive and staff nurses where we may eventually get together the right position and the right woman to fill it to the mutual advantage of both. One

thing must be remembered, and that is the status of the staff and their living conditions. It is getting more difficult to get the right women to take these complex positions, and, in order to fill them with satisfaction, changes must be made in living conditions and salary. Graduate nurses must be well paid if they are to be properly qualified, and the authorities must realize just how valuable or destructive to the success of the hospital the executive head is. An increasing salary schedule, proper, comfortable housing, representation at board meetings, vacation and relief must be offered before these positions are alluring to the specially trained and equipped registered nurse.

To sum up, what has been the value of the inspection of the training schools? It has brought about a closer understanding of what the pupils must have in the school and also a better understanding of the difficulties the hospital boards have in financing this department of the hospital. They learn, perhaps for the first time, that it is really a separate department of the hospital. It gives them a chance to talk over special and general problems and to get together on many points. It shows them that the G. N. A. of B. C., by financing this inspection and giving this help, is unselfish in the desire to improve conditions and to give relief to the problems of the board when possible. It opens the way to correspondence regarding positions to be filled, situations to be met and problems to be solved where advice can be asked freely. It shows the hardships of the executive heads of small hospitals and should point some way to give relief. It shows the deplorable lack of any satisfactory record of the nurses training and of equipment and teaching facilities in most schools. That a Nurses' Home is or should be one of the first requisites of any hospital planning has to be dwelt upon more and more. It, a separate home, is beginning to be recognized as an economical factor in keeping the pupils happy and well, and therefore doing better work. The time will come through this inspection that we shall have closer co-operation between boards of the G. N. A. of B. C. and a central training school, affiliation between both large and small hospitals giving a training in both to all students, and an insistence on the grading of nurses for qualifications for staff or executive positions.

In conclusion, let me urge that in each province where registration is in force, that the provincial association take up this work of visiting the training schools and inspecting them, thus acting as a medium between school, the registration committee and the hospital boards.

Let us all urge all methods towards a better and more uniform curriculum and training in our own provinces — leading to uniformity between provinces and finally Dominion-wide regulations. The first step being an insistence on proper qualifications for the heads of training schools and help given to such nurses as are ambitious to get such special training. Sufficient teaching staff both inside and outside the school, proper equipment, and school-rooms must be obtained, where the nurses

may study comfortably. Remember that hospital boards are usually doing their best, but old traditions die hard, and it is difficult to demonstrate that obsolete methods must be done away with. Exploitation of pupils must be eliminated, as it can only be done by tactful education of board and staff. Clearer conception of the obligations of hospital boards towards their students, as demonstrated by the inspector of these schools, will show the value of these inspections.

—Read at the C.N.A.T.N. Convention, Edmonton, 1922.

WEEDING THE FAMILY MEDICINE CHEST

Weeding out is usually the first step in revolutionizing a ready stocked medicine chest. Begin by banishing *all* patent medicines—liquids, pills, or powders. Notwithstanding the volumes written to warn the public against these nostrums, drug stores continue to do a flourishing business in them. Many of the widely advertised "cures" contain such poisons as coal tar derivatives. Practically all so-called "tonics" are 50 per cent. to 75 per cent. alcohol. Some of the cough syrups religiously purchased year after year by trusting mothers have camphor as their chief ingredient—a drug that produces convulsions when taken freely. Calomel, a household "remedy" in certain sections of the country, and administered indiscriminately to young and old, is a derivative of mercury. Taken in large doses, or too often, it may cause symptoms of mercurial poisoning, while its effect upon the teeth and gums is especially harmful. In its place calomel is a valuable drug, but the doctor is the only person whose judgment may be relied upon as to its proper use. Headache remedies generally, and such popular favorites as aspirin, veronal, phenacetin and strychnin in particular, are doubly dangerous to the layman because of their habit-forming nature.—CLARA D. NOYES, R.N., in *The Health Builder* for November.

No one can know the shortcomings of the school better than those responsible for it. The best and the worst in our nursing work are not due to the schools, primarily, whatever be their virtues or faults, except as conditions in them are such that good applicants are deterred from entering, but are due to the inherent qualities brought to the schools in the persons who present themselves as applicants. If by birth, environment and education they have ideals, intelligence and mental culture, the result is almost sure to be satisfactory, and every effort made to attract that type of young woman redounds to the credit of the hospital and school from which she graduates.—"History of the Massachusetts General Hospital Training School," by Sara E. Parsons.

Lectures on The History of Nursing

WITH DESCRIPTIVE LIST OF LANTERN-SLIDES

By MAUDE E. SEYMOUR ABBOTT, B.A., M.D.,
Curator of the Medical Museum, McGill University

LECTURE XI.

(Continued from last month.)

THE ST. JOHN AMBULANCE ASSOCIATION AND ITS ORIGIN UNDER THE ORDER OF ST. JOHN OF JERUSALEM. RECENT WAR ACTIVITIES UNDER THE JOINT WAR COMMITTEE OF THE BRITISH RED CROSS AND THE ORDER OF ST. JOHN. * †

One of the most interesting features of military nursing to-day, from the historical standpoint, is the survival, in the St. John Ambulance Association, of the philanthropic practice and ideals of the old mediæval order of the Knights Hospitallers of St. John, and the revival of the ancient prestige of the Order through the magnificent work done by its members during the recent war in amalgamation with the British Red Cross under the title of the "Joint Committee of the British Red Cross Society and the Order of the Hospital of St. John of Jerusalem." It is interesting to learn from a recent decision that the "Joint Committee" is to continue in operation and to prosecute its works as such under the peacetime policy of the League of Red Cross Societies, so that this honourable name, and the tradition that lies behind it, is to have an acknowledged part in the present world movement for the defence of the public health. In this particular, too, history has fulfilled itself, for in mediaeval times the Knights of St. John were an international organization with membership in eight different countries, and carried on the hospital work that was their peculiar province in a spirit that made it, in the words of Nutting and Dock, akin to Red Cross work.

Origin: The following facts not already outlined in Lecture IV. in regard to the early history of the English *"Langue"* are of interest, as the St. John Ambulance is an institution of this division.

The first land owned by the order in England was a grant of ten acres in London to the Order, by Jordan de Briset of Elthan, in Kent, in 1130 A.D. On it the great Clerkenwell Priory (which latter word was the name given to the chief seats of the *"Langues"* in the various countries) was soon after erected. It was an imposing structure, containing the hospital, church, halls and dwelling-place of the Knights. During the succeeding five hundred years the Priory took a leading part in English court life and was a favourite place of entertainment for the

* See Lecture IV. on the origin of the Order of St. John.
† Copyright November 23rd, 1920.

English kings and their royal guests, who were sometimes in residence there for weeks at a time.

Once established, the Order grew rapidly in wealth and extended widely, so that in 1338 it owned ninety-nine manors in various parts of England, and large properties in Scotland and Ireland, besides other parts of London itself, such as Lincoln's Inn Fields, St. John's Wood, etc. Its prosperity in England reached its height in the reign of Henry VII., who became its Protector. At this time the Lord Prior of the Order Sir Thomas Docwra, restored the Priory building and expended large sums in beautifying it, and erected the great St. John's gate-house and the tower of the church. During the early part of the reign of Henry VIII., Sir Thomas Docwra was high in favour, and, when Grand Master De l'Isle Adam came to the Priory after the fall of Rhodes, Henry visited him there, presented him with ammunition for the help of the Order, and himself entertained him in return at St. James' palace. The reverses of the Knights began very soon after this with the quarrels between King and Pope. A royal decree in 1540 A.D. enforced the dissolution of the English *Langue*, with confiscation of all their property to the Crown, members being forbidden to wear the dress of the Order or to use its titles. The Knights fled to Malta, but not before several of their leaders had been beheaded or hanged. On the accession of Queen Mary these decisions were reversed and a charter was given, reinstating them in all their ancient privileges, but, as soon as Elizabeth ascended the throne, their property was again seized and the Knights were again forced to fly to Malta. From that time, for several centuries, the English Langue existed only in that Island, until, in 1798, Napoleon made himself master of Malta, and carried the greater part of the treasures of the Order, in church, palace and hospital, away on his flagship, which was sunk with its entire load by Nelson in the Bay of Aboukir. The Knights were scattered over Europe and many returned to England. Early in the nineteenth century the French Knights resident in Paris obtained the reconstitution of the Order as a militant body, to fight in aid of the Christians in the war between Greece and Turkey, and invoked the aid of the English, in a document which re-established the English branch and prescribed that its members might be members of the Anglican Church. The Charter of Queen Mary, which had never been revoked, was, however, the document upon which the English Division actually rested until 1888, when a new charter was given by Queen Victoria confirming the Knights in their privileges and acknowledging their claim to exercise ambulance and nursing functions, which they assumed from the time of the Franco-Prussian war on.

Origin of St. John Ambulance Association.

It was at this time (1870-71), as a result of experiences gained as members of the British National Society for the Aid of the Sick and Wounded in War, behind the Franco-Prussian lines, that certain

Knights of St. John, feeling that it was impossible to conduct organized relief in time of war, unless preparatory work were done also during peace, took the action that resulted in the organization of the *St. John Ambulance Association*. The first centre was formed at Woolwich and was quickly followed by others in London and the provinces.

The chief function of the Ambulance Association was the training of pupils in First Aid for emergencies and in light ambulance work; courses of instruction were also given in home nursing and sanitation. In consequence of this instructional work by the St. John Ambulance Association a natural desire arose on the part of its students and certificate-holders in first aid for coöperation, and as a result *Ambulance Corps* were formed in various parts of the country. In the year 1887 these were combined in a single organization known as *the St. John Ambulance Brigade*, which is thus an association of trained first aid workers co-ordinated together for purposes of national relief.

The work of the St. John Ambulance Association and the organization of the St. John Ambulance Brigade soon spread from Great Britain to her dominions overseas, beginning with New Zealand in 1892 and proceeding rapidly over Australia, Canada, India, Ceylon, Malta, Newfoundland, New Zealand and South Africa. An important phase of the educational work of the association in peace has been the awarding of trophies for competitive examinations in first aid. In the organization of the Order to-day, which has been arranged under the charter as far as possible, on the precedent of the old Order, the Sovereign of the Realm, King George V., is the Patron, and all admission to the Order must receive his sanction. The Grand Prior or Principal Kinglet is H.R.H. Duke of Connaught, who was elected on the eve of St. John the Baptist, in 1910, and exercises the government. Next in precedence is the Sub-Prior, then the Bailiff of Egle, then the Knights of Justice, Ladies of Justice, Chaplains, Knights of Grace, Ladies of Grace, Esquires, Serving Brothers and Sisters, Honorary Associates and Donats. The grades of Lady of Justice and Lady of Grace are among the few honors conferred on women for national service to-day. The high honour of Lady of Justice has been conferred upon only one Canadian woman, Lady Grace Julia Drummond. Some twenty-two Canadian women have been admitted under the title, Lady of Grace, and three have been made "Honorary Serving Sisters."

The St. John Ambulance in War.

During the South African war (1899-1902) the St. John Ambulance sent 2000 men members, who were attached as hospital orderlies to the R. A. M. C.; of these 70 lost their lives.

In the year 1909 a system of Voluntary Aid Detachments was inaugurated by the British war office for the assistance of the Territorial (voluntary) Force, as a part of its medical service, or of that supplied

for it by the British Red Cross. These detachments were to consist of bodies of men and women trained to supplement the Military medical personnel in clearing hospitals, rest stations, and ambulance trains. In 1910 this organization was perfected, and it was then announced that *"a Brigade or County Company of the St. John Ambulance may be regarded as equivalent in every respect to a voluntary aid detachment."* The St. John Ambulance Brigade thus became recognized as a part of the British Technical Reserve. During the next four years organization of V. A. D. Detachments proceeded rapidly, so that at the outbreak of the Great War its personnel numbered 84,352, of whom 67,714 were from the British Red Cross and 12,628 V. A. D. members of the Order of St. John (men and women). At the Armistice these figures had increased to 90,623 Red Cross and 35,070 Order of St. John V. A. D's. Of the latter, 24,440 were women and 10,630 men. These trained first aid workers were utilized throughout the war to augment the medical units of the regular forces, the men in the capacity of orderlies and the women as V. A. D's, who took a similar place on the nursing staff of the military hospitals as do the probationers to the trained nurses in a civil institution. As the war advanced the V.A.D. ranks multiplied rapidly by members drawn chiefly from the highest and best educated class of society, who performed their duties with remarkable zeal and an efficiency that won the highest commendation. In the words of the Joint War Committee of the British Red Cross and the Order of St. John, it was "beyond praise."

(To Be Continued)

BE READY

Hast thou a cunning instrument of play?
'Tis well. But see thou keep it bright
And tuned to primal chords, that so it may
Be ready day and night.
For when He comes thou know'st not, who shall say:
"These virginals are apt"; and try a note
And sit, and make sweet solace of delight
That men shall stand to listen on the way,
And all the room with heavenly music float.

T. E. BROWN.

A beautiful and chaste woman is the perfect workmanship of God, the true glory of angels, the rare miracle of earth, and the sole wonder of the world.—HERNES.

Editorial

Your Magazine

From time to time, once at least each year, through these pages and at each convention, the Editor endeavors to bring before the readers of the magazine, and particularly to every member of the C. N. A. T. N., who own this *Canadian Nurse,* the need of active and never-ending work in the financial support of it through both subscriptions and advertisements. It has had hard and anxious years since the association bought it in 1916—through war-time, when prices for paper and labor rose to unprecedented heights, and are now far higher than in our first year. While, naturally, one expects that the active work and worry should be taken care of by the business office, still, as each one of you is a partner in this business activity of the C. N. A. T. N., it is also your part to take your share of both. That the nurses of Canada do not support it as a whole is only too true. While we have not the numbers of organized nurses in all the provinces at our disposal, still, by calculating from such information as is available, we are ashamed to face the percentage given as subscribers per province. The *American Journal of Nursing* has been giving the names of states and their percentage, and in Canada, to one's dismay, not one province's subscriptions reach 50% of membership.

Do we want a Canadian nursing journal? Do we feel the need of one to the extent of paying $2.00 as the individual share of the financial responsibility taken by us when our delegates all voted to buy it in 1916? If it is not all you wish in a nursing journal, ask yourself if you have done everything possible to make it your ideal magazine by support and contributions.

Personal canvass and constant work is the only way that the subscribers can be secured, and when purchasing materials, etc., through the advertisements, or when writing to advertisers, it would help if the *Canadian Nurse* magazine was mentioned. In addition to both these means of helping come the contributions.

It is difficult to explain that not all that comes to the office is suitable material, and yet keep from discouraging possible contributors. It must be said, however, that the magazine needs and wants constructive articles giving help in any field of nursing, descriptions of practical nursing procedures, helpful suggestions that the private nurses have found to be useful, and which the younger nurses just setting out to work in the field of private duty nursing would value so much. Our ranks are full of embryo contributors, if they would only set their minds to work for the general good. If our training schools hold the reputation for good solid

training that they do, surely those responsible for the education of these pupils must have wonderful possibilities in their possession which would be read and re-read if lent to the magazine. The curse of the world to-day is the dislike for responsibility and a shirking of what stands as the immediate duty of each one. We all have these responsibilities, and one of them as professional women—nurses of Canada—is to take the magazine on the shoulders of each individual nurse and work together, with the officers and Editor of the magazine, in its interest.

Cultivate forbearance till your heart yields a fine crop of it. Pray for a short memory to all unkindnesses.

The truly valiant dare everything except doing anybody an injury.
SIR P. SIDNEY.

Who overcomes by force, hath overcome but half the foe.—MILTON.

Of all the crowns that ever were awarded, the crown of simple patience is the best.—WILLIAM WINTER.

I muse on joy that will not cease,
Pure spaces clothed in living beams,
Pure lilies of eternal peace,
Whose odours haunt my dreams.
SIR GALAHAD.

Common sense is, of all kinds, the most uncommon—it implies good judgment, sound discretion, and true and practical wisdom applied to common life.—TRYON EDWARDS.

All that is best in the civilization of to-day is the fruit of Christ's appearance among men.—DANIEL WEBSTER.

Civility is a charm that attracts the love of all men; and too much is better than to show too little.—B. D. HORNE.

News from the Medical World

By Elizabeth Robinson Scovil

A Memorial

Sir Arthur Currie recently unveiled a stained glass window at McGill, a memorial to three members of the Faculty of Medicine killed during the war. They were Lieut.-Col. John McCrae, author of "In Flanders' Fields," Lieut.-Col. R. P. Campbell, and Lieut.-Col. H. B. Yates.

Cold in the Head

A medical authority recommends rest at home and possibly in bed for a day or two, a simple laxative, light food, a foot bath and a warm drink, to combat this simple ailment. It may save a patient from pneumonia, bronchitis, or severe inflammation in the nose and sinuses.

Uterus After Caesarean Section

In a report of two cases of labor following a previous caesarean section, it is said that in one case the uterine muscle ruptured but the scar remained firm. In the second case the uterus was the seat of so much fatty degeneration that extensive rupture occurred as soon as labor began. This patient had had no opportunity to recover properly from the previous section.

Cancer Cures

Lord Athelstan, of the Montreal *Star*, has offered $100,000.00 for the discovery of a cure for cancer. As a result, 2,715 claims have been received from 41 different countries. The Royal College of Physicians and Surgeons advised that claimants must satisfy a recognized medical authority in his or her own country that there is some scientific basis to justify the experimental investigation of the professed cure and that any cases said to be successfully treated were really cases of cancer.

Controlling the Heart Rate

A medical man writes, "One can voluntarily control the rate of the heart by so simple a means as the respiration." Deep, slow respirations cause a slowing of the pulse; rapid, shallow respirations an increase in the rate. If the breath is held for long, the rate becomes rapid and apparently irregular in every case, whether at the end of expiration or of inspiration.

Sleep and the Baby

A doctor says the young infant cannot get too much sleep, and this is best attained by filling his stomach at regular intervals.

Rate of Secretion of Breast Milk

It is stated that nursing infants obtain the greater part of their feeding of breast milk in the first few minutes after beginning nursing. This holds true whether the supply is abundant, moderate or scanty. After eight minutes very few babies who need both breasts usually get less from the second side than from the first.

Physicians and Prohibition

One hundred and five prominent physicians of New York City have begun a movement to force the annulment of the restrictions on prescriptions for whiskey established by the Volstead Act. It is not an anti-prohibition movement; all the physicians concerned in it are opposed to the promiscuous and wide-open sale of intoxicants. It is intended to prevent the further invasion of the professional rights of physicians as conservators of the health of the people.

Illuminated Forceps and Tenaculum

A Seattle physician has introduced a tonsil tenaculum and artery forceps with a Cameron lamp attached. Any standard lamp may be used. After the removal of the tonsil, the tonsil fossa is sufficiently illuminated for the bleeding point to be seen. It can be grasped accurately with the forceps and sutured or ligated. It may be used in emergency hemorrhage in the home, and is very simple.

Physiology of Rigor Mortis

According to recent researches, the stiffness of the muscles occurring after death seems to be identical with muscular contraction. In both cases lactic acid is formed, which causes the muscle fibres to swell through the absorption of water, whereby the tension is increased. When the structure of the muscle fibres is broken down the rigidity also disappears.

Purgation

It is stated that merely because a person is sick is no reason for a purge. Most patients are best helped by water, food, and such hygienic measures as tend to build up his resistance. If the lower bowel needs emptying, it should be given with the same care and thought as any other drug.

Price of Radium

The United States Geological Survey announces that the price of radium has decreased owing to the discovery of vast quantities of radium-bearing ores in Africa, which are easily worked at a much lower cost than the American mines. It is now $70,000 a gram, the lowest price at any time since radium has been used; it was $120,000. In connection with cancer work, the State of New York and the city of Philadelphia each bought two grams for the use of their citizens, and Quebec bought one gram.

Dried Milk in Infant Feeding

The United States Public Health Service has been examining the suitability of dried milk powders for infant feeding, and concludes that there are now available dried milk powders from which products may be re-made that are safe for infant feeding. This is especially true of the whole milk powders. Dried milk is only to be used when good fresh milk cannot be obtained.

Clemency is profitable for all; mischiefs continued lose their force.

Stretch.

Behaviour is an image in which everyone displays his image.

Goethe.

Great deeds cannot die;
They with the sun and moon renew their light,
For ever blessing those that look on them.

The Princess.

In Love, if Love be Love, if Love be ours,
Faith and unfaith can ne'er be equal powers:
Unfaith in aught is want of faith in all.

It is the little rift within the lute
That by and by will make the music mute,
And, ever widening, slowly silence all.

Vivien.

Live—yet live—
Shall sharpest pathos blight us, knowing all
Life needs for life is possible to will—
Live happy; tend thy flowers; be tended by
My blessing! Should my Shadow cross thy thoughts
Too sadly for their peace, remand it thou
For calmer hours to Memory's darkest hold,
If not to be forgotten—not at once—
Not all forgotten.

—*Love and Duty.*

If we would have anything of benefit, we must earn it, and, earning it, become shrewd, inventive, ingenious, active, enterprising.

H. W. Beecher.

Public Health Nursing Department

OFFICERS:

Chairman—Miss Florence Emory, 26 Algonquin Avenue, Toronto, Ont.
Vice-Chairman—Mrs. Hannington, 104 Sparks Street, Room 4, Ottawa, Ont.
Secretary—Miss Muriel Mackay, 190 University Avenue, Toronto, Ont.

Address public health news items from each province to the following representatives:

Nova Scotia
Miss Mackenzie,
Superintendent Nursing Service,
Provincial Dept. of Health,
Halifax, N. S.

New Brunswick
Miss Harriet Meiklejohn,
Health Centre,
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Quebec
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The Ontario Board of Health has $115,000 annually at its disposal for combating venereal diseases. One-half of this amount is from the Federal Government and one-half from the Provincial Government. This money is for the payment of salaries, travelling expenses, educational purposes, free treatment of patients, free apparatus and equipment, and, if necessary, making of Phenarsenamine (606) or such other drug as is considered advisable. Clinics have been established in the larger centers —Ottawa, Kingston, Hamilton, London, Windsor, Owen Sound, Brantford, St. Catharines, North Bay, Peterborough, and six in Toronto.

The provincial board pays fifty cents for each out-patient treatment, and also fifty cents a day for in-patients, for a period not exceeding three months. Phenarsenamine (606) is supplied free to all clinics. Five hundred dollars is paid annually to the physician in charge of the clinic; also $500.00 is paid toward the salary of the Social Service nurse. Free record forms are supplied. One thousand dollars is paid for purchasing apparatus and equipment, according to a schedule prepared by the board.

Each clinic is required to have a Social Service nurse. The appointments are made locally, and the salary, over $500.00, is paid by the local board of health. While it is highly desirable that nurses in this special

field of nursing should have special training, in the agreement between the provincial and local boards, the requirement is, "the nurse shall be a graduate of a recognized training school." However, the provincial board advises that, immediately an appointment has been made, the nurse should spend three weeks or a month in Toronto observing the public health nursing in operation there. Opportunity is given to observe court procedure, probation, parole, and methods of co-operation with other agencies, as well as to become familiar with the provincial plan of organization. Reports of work are made to the provincial board monthly.

In towns and rural districts where clinics would not be feasible, free Phenarsenamine and apparatus, as necessary, is supplied. The service of a specialist is also provided for the first treatment.

Treatment in provincial institutions is as follows:

(a) In reformatories and industrial farms the treatment is carried out by a specialist from the provincial board, who visits the institutions weekly. The board supplies Phenarsenamine, and the institution provides the apparatus and equipment.

(b) In Ontario hospitals for the insane, free Phenarsenamine with apparatus and services of a specialist for the first treatment is supplied, after which the institution is expected to carry on treatment by means of its own medical staff.

(c) Free Phenarsenamine for other hospitals throughout Ontario may be obtained through the local medical officer of health.

Circular letters have been written to doctors, dentists, and druggists, dealing with various phases of the venereal disease problem.

Pamphlets have been printed for the use of the general public and also for patients under treatment.

Phenarsenamine is manufactured and supplied for the free treatment of patients who are unable to pay.

Films for the education of physicians, nurses and the general public have been purchased and are being shown throughout the province.

There are nine laboratories in Ontario, at Ottawa, London, Kingston, Fort William, North Bay, Sault Ste. Marie, Peterborough, Owen Sound, and Toronto. These are available for free laboratory diagnosis of syphilis and gonorrhoea.

Follow-up work in connection with Ontario hospitals for the insane is under way, and the contacts are examined in most cases of general paralysis.

Patients moving from one municipality to another during treatment are transferred through the board, in order that treatment may not be discontinued.

Canadian and American publications inserting ads concerning irregular treatment of venereal diseases are warned, and, if necessary, prosecuted.

All possible assistance is given to local boards of health.

The provincial board is working in close conjunction with the Canadian Social Hygiene Council, especially in their propaganda work.

EDNA L. MOORE.

Public Health Nurses in Venereal Disease Clinics

Venereal disease nursing is a new field of effort for the public health nurse, but one in which she has already proven her value. She has become the "aids" of the medical officer in the fight against this disease. As a result of her efforts the efficiency of the venereal disease clinic has been increased many times, and through these clinics she has given valuable service to the individual patient and the community.

The duties of public health nurses in connection with venereal disease clinics may be dealt with under three heads:

(1) Duties in the clinic;
(2) Duties in relation to the home and social environment of patients;
(3) Duties in relation to the Community.

1—DUTIES IN THE CLINICS

The duties of the public health nurse in the clinic require her attendance at all clinics, and include the doing of anything which will contribute to the smooth running and efficiency of the clinic. In some cases it may mean that she is responsible, on clinic days, for the arrangement of clinic equipment, the preparation of the treatment room, and the giving of assistance to the clinic physician in carrying out treatment. Where these clinics are connected with a hospital, a pupil nurse is usually detailed to this duty. The latter arrangement is as it should be, in order that the public health nurse be relieved for duties which more particularly belong to her.

Interviewing Patients

The pubic health nurse interviews each new patient. In these interviews she obtains the information required for the social history records; she explains to the patient the nature of the disease, the necessity for regular and continued treatment, and the danger of infecting others. If home treatment is ordered by the clinic physician, she also explains the method of carrying out such treatment. (In the case of male patients this is done by the physician.)

Correction of Physical Defects and Teaching Health Habits

The public health nurse, working in these clinics, is interested first in securing for her patient a cure for venereal disease; but she is interested also in helping him to become, as near as possible, a physically

perfect individual, living a life consistent with health. She will, therefore, be alive to, and report to the physician for diagnosis, any symptoms which would indicate the presence of other physical defects in her patient. If such defects are found to exist, she will bring to bear all the resources of her hospital to secure the correction of these defects and the instruction of the patient in health habits.

Records and Reports

The public health nurse is responsible for the social service histories and records of the clinic patients, and for various reports that are sent out from the clinic from time to time.

It becomes her duty to see that the social history forms are filled out as accurately and completely as possible, and that the information, when obtained, is made use of and referred to the proper sources, *i.e.*, the names of contacts and sources of infection to the local or provincial boards of health, bawdy houses and persons of questionable character to the police for investigation, and social problems to the proper social agencies.

Clinic Atmosphere

There is something quite characteristic of each clinic, not easily defined, but which may be called "clinic atmosphere." Upon this depends to a large extent whether the clinic attendance keeps up, whether the patients attend willingly, or whether they will only attend when compelled to do so. The public health nurse can do a good deal toward creating a "good atmosphere" in her clinic. The time spent in speaking a friendly, encouraging word to the patients as they come in, showing a little personal interest in them and their affairs, and straightening out any difficulties that may arise between patient and physician or hospital is well spent, because of the return it brings in increased attendance and contented patients.

2—Duties of Public Health Nurses in Connection With Home and Social Environment of Patients

Unless there is a good reason to the contrary, and this to be decided after consultation with the clinic physician, the public health nurse should personally visit the homes of each patient attending the clinic for the treatment of venereal disease. The first visit should be made as soon as possible after the admission of the patient to the clinic. This is important because of the necessity of verifying addresses. It has been our experience that the addresses given are frequently incorrect, and that it is only when a visit is made *re* non-attendance that it is discovered that this is so.

The purposes for which visits are made to the homes of these patients are:

To Secure Regular and Continued Attendance at Clinic

Much valuable time and effort is wasted in clinics of this kind in

treating patients who attend for a few times and then discontinue treatment while still uncured. The treatment of these diseases is long and tedious, and frequently painful. The patients become discouraged, and, their acute symptoms having disappeared, they discontinue attendance at clinic, frequently disappear and are lost. The nurse, by visiting these patients in their own homes and explaining carefully and repeatedly the necessity for continued treatment and the danger of insufficient treatment, is able many times to bring about in the patient an attitude of mind which is more important in keeping him under treatment than all the laws or police authority in the land. If persuasion fails, she has, of course, recourse to the law through the medical officer of health.

The nurses, too, have an uncanny way of finding, through neighbors, employers, and even cartage and moving men, patients who attempt to lose themselves.

To Explain the Method of Carrying Out Home Treatment, and to See That It Is Carried Out as Ordered

The routine treatment ordered by physicians in clinics for the treatment of gonorrhoea, which consists of daily vaginal douches of one solution or another, is an important aid in clearing up the disease and reducing the length of time during which the patient must attend clinic. Without instruction, few of these patients are able to carry out this treatment in a manner to make it at all effectual. In the surroundings under which many of them live there may be no opportunity to take the treatment at all, and many of them have not the proper facilities. The lack of time and privacy make it impossible for the nurse to give, during clinic hours, the detailed instruction necessary in these cases. She is able to do this much more effectively in the home by actual demonstration, if necessary. In the case of gonorrhoeal vaginitis in children, treatment will always have to be demonstrated. In some cases it may be necessary to secure for the patients douche bag and pan through some relief organization.

To Secure the Examination of Contacts and Sources of Infection

This part of the work in connection with venereal disease clinics is that which is most difficult, and requires the greatest amount of tact and understanding on the part of the nurse.

A quiet talk to the person concerned, in the privacy of their own home, will often secure the results desired, and abort the domestic tragedy so often threatened in these cases.

To Keep Informed of the Conditions Under Which the Clinic Patients Are Living

The public health nurse cannot say with certainty that her patient is carrying out the rules of the clinic in regard to treatment, conduct, etc., unless she knows something, from personal observation, of the manner of living of the patients attending her clinic. It is for this reason

that the clinic nurse feels justified in keeping her patient under a certain amount of supervision, even though they may be attending regularly for treatment. It is rather embarrassing for the nurse to learn, for example, that the patient who has been attending the clinic regularly for treatment has been all the time (without the knowledge of the nurse) an inmate of a house of prostitution.

In visiting these homes the nurse frequently has the opportunity to do real missionary work by discovering and remedying ills, both physical and social; illness, unemployment, non-attendance at school, immorality in the home. These conditions, when discovered by the nurse, may be referred to the proper social agency to secure a remedy.

3—The Duties of the Nurse in Relation to the Community

The first duty of the public health nurse in a venereal disease clinic is, of course, the securing for her patient a cure of the disease for which he has come to the clinic. By doing this well she is also rendering a service to the community, for she is preventing the occurrence of other cases of disease, which would have resulted in those exposed, if the patient had remained untreated and uncured. But, to be complete, her work must extend outside the clinic, and she must endeavor to prevent the occurrence in the community of the cases which are forever feeding the clinics. In order to do this she must deal with

The Contacts and Sources of Infection of Clinic Patients

The patient attending the clinic for the treatment of venereal disease is only one link in the chain of disease. Those who have been exposed to him are, if diseased, so many potential sources of infection, and should be dealt with as such. The public health nurse who is truly "on the job" will not rest until this is accomplished, either by persuasion or by force of law.

The Conduct and Mode of Living of Patients Attending Clinics

Those who are concerned with the treatment and cure of venereal disease have a responsibility toward the public which is greater than that of persons treating any other disease. This is true because the law of the country and medical ethics demand that these diseases be treated with a certain amount of secrecy, and forbids the giving of information concerning persons so infected. Those concerned in treating such persons owe it to the public to see that, so far as in their power, these persons shall not, either innocently or otherwise, expose others to infection. The working out of this principle is difficult. For example, a woman under treatment for an acute gonorrhoea may be employed as domestic in a home where there are little children. The patient should not be allowed to remain in her position; the risk of infection is too great. The clinic nurse, knowing the facts, is not permitted to inform the mistress of the girl's condition. She must handle the situation, or else it will be necessary

to notify the medical officer of health, who, in his turn, would inform the mistress of the danger of the situation.

Medical authorities have long contended that, in dealing with venereal disease, they were concerned with the physical and not with the moral sides of the question. Experience has proven that, in considering this disease, the physical and moral sides of the question are so intimately connected that they cannot be dealt with separately. A sexually promiscuous individual is almost always venereally diseased, is rarely completely cured, and, if diseased, is always a spreader of infection. The old idea that a diseased prostitute is safe if under treatment has been thoroughly exploded. The conduct in regard to sex matters of the persons attending the venereal disease clinic becomes, then, a matter of concern to the public health nurse. She may not be able to change the conduct of these persons, but should refer them to those organized to exercise some control over it.

Foci of Infection

There exist in every community certain places and conditions which may be said to bear the relation to venereal disease that the stagnant water pool bears to malaria. These plague spots of our cities—bawdy houses, rooming houses where immoral conduct is ignored or winked at, taxicabs used for immoral purposes, certain foreign restaurants which are nothing more than places of assignation, and certain dance halls where prostitutes congregate—are an important factor in the spread of venereal disease, and their removal and supervision is as much the concern of the public health worker as is the filling up of the water pool in the case of malaria.

Much valuable information may be obtained from the patients attending venereal disease clinics concerning the location and operation of these places, and the nurse will see to it that this information is referred to those who have authority to deal with it.

Prevention

It is now a known and acknowledged fact that prostitution, either professional or clandestine, is the chief factor in the spread of venereal disease. Prostitution is a complicated social phenomenon bound up intimately with such other social problems as double standards of sex morality, mental deficiency, bad housing, lack of home training, lack of proper facilities for dealing with sex delinquents in courts and penal institutions, etc. The nurse in the venereal disease clinic is in a strategic position to gather data concerning the relation of these problems and prostitution, which means venereal disease. Once having obtained the information, she will not be content until it is placed in the hands of those agencies organized to make use of it.

The field of endeavor for the nurse in venereal disease clinics is wide and her opportunities for service are many. In order to meet these

opportunities she must be a person with special qualifications, which include a good technical training, intelligence and vision, and a fund of human sympathy and understanding.

FRANCES BROWN.

SOME WAYS TO KILL AN ORGANIZATION

A few ironical hints were read at a recent meeting of the American National Organization of Trade Association Secretaries:

1. Don't come to the meetings.
2. If you do come, come late.
3. If the weather doesn't suit you, don't think of coming.
4. If you do attend a meeting, find fault with the work of the officers and other members.
5. Never accept office, as it is easier to criticize than to do things.
6. Nevertheless, get sore if you are not appointed on a committee; but if you are, do not attend the committee meetings.
7. If asked by the chairman to give your opinion regarding some important matter, tell him you have nothing to say. After the meeting, tell everyone how things ought to be done.
8. Do nothing more than is absolutely necessary; but when other members roll up their sleeves and willingly, unselfishly use their ability to help matters along, howl that the association is run by a clique.
9. Hold back your dues as long as possible, or don't pay at all.
10. Don't bother about getting new members. Let the secretary do it.
11. When a banquet is given, tell everybody money is being wasted on blow-outs which make a big noise and accomplish nothing.
12. When no banquets are given, say the association is dead and needs a can tied to it.
13. Don't ask for a banquet ticket until all are sold, then swear you've been cheated out of yours. If you do get a ticket, don't pay for it.
14. Keep your eyes open for something wrong, and, when you find it, resign.
15. When you attend a meeting, vote to do something and then go home and do the opposite.
16. Agree to everything said at the meeting, and disagree with it outside.
17. When asked for information, don't give it.
18. Get all the association gives you, but don't give it anything.
19. Talk co-operation for the other member with you, but never co-operate with him.
20. When everything else fails, blame the secretary.

—From Rotary Menu Card.

Private Duty Nursing Department

Secretary-Treasurer—Miss Bertha M. Fife, 320 Roncevalles Avenue, Toronto.
National Convenor—Miss Edith Gaskell, 397 Huron St., Toronto.
Convenor Press Committee—Miss Isabel Crosby, 97 Avenue Road,
Nova Scotia Representative—Miss Josephine Walsh, 41 Brenton St., Halifax, N. S.
Quebec Representative—Miss Florence Thompson, 165 Hutchison St., Montreal, Que.
Ontario—Miss Helen Carruthers, 34 Whitney Ave., Toronto, Ont.
Manitoba Representative—Miss Henrietta Sykes, 723 Wolsely Avenue, Winnipeg.
Saskatchewan—Miss Helen Cameron, 717 Dufferin Ave., Saskatoon, Sask.
Alberta Representative—Miss Agnes Kelly, 457 Twelfth St. N.W., Calgary, Alta.
British Columbia Representative—Miss Marion Currie, 2707 Hemlock St., Vancouver, B. C.

The Private Duty Nurse and the Association

AN EX-PRIVATE DUTY NURSE

The title of this little article is quite enough for my fellow-nurses in active service to hold up hands in horror and say, with indignation, "It's quite evident that she is an 'ex,' and not as busy as I am, or she would not suggest any very active connection between associations and private duty nurses." In spite of this scathing condemnation of the title, the fact remains that we, nine-tenths of the graduate nurse forces of the world, must have active connection and active work with and for the association if we are to be considered as part and parcel with the other branches of the profession which do feel the need of co-operation and activity in order to come up to the mark. The C. N. A. T. N. evidently felt this when the recent section of private duty nurses was arranged for. Quite in the family, and where no others can hear us, let us whisper that sometimes there is just the tiniest feeling deep down and carefully squelched that perhaps we asked for more than we really do want. Isn't that heresy? Only a member of the "noble army" would dare to suggest this. One of the hardest things is to convince the private duty nurse that she really does need these meetings and can find time for them at least some months in the year. The profession generally needs the private duty nurse, too, and somehow or another the need must be felt and met.

One of the complaints heard about ourselves is that we forget that we are anything more than nurses and have nothing more to think about and talk about than our last case and other professional gossip which is

one thing and about the only one ever discussed where groups of nurses gather at the hospital table when "specialling." Would it interest you if a current events class or rather talk could be given each month? It might be arranged for at first by someone, a married nurse, for example, or one interested in nurses from the Local Council or other body of women who could make this subject most interesting. A suggestion is that, after the first year, it be left to the nurses themselves to gather data on the current events of the day which certainly, in these days, make history. How few of the private duty nurses read their newspaper with any degree of interest in anything but the local affairs, and have any idea of the world and its affairs! A course in parliamentary usages would help many a nurse to bring her views to the attention of the gathering with confidence that she was doing it in the correct and proper manner. Another series describing the laws relating first to her profession and then to women generally which are in force in her own province would make it clearer how careful one should be as a voter to send the best we have to the Capital. Do you say that these are all very well, but it is not nursing? No, that is true, but we are women first and nurses afterwards, and above all we are citizens and have the franchise. In addition to these series it would help much if practical nursing procedures of recent date were discussed and possibly demonstrated.

The private duty nurse knows, as probably no one else can know, just how far short her own training fell of giving her the poise and equipment for the special work she has to do. Meeting all sorts of people, with all sorts of homes and equipment to work with, all sorts of situations to be met, it must surely have struck all of us how very casually we were sent out from the training school, where we always had someone to appeal to for help and supervision—out quite on our own, and expected to make good at that. We all could bring up reminiscences of the early days of our public life which would be a revelation to those who have never had to face the strange door with a sinking heart and a secret dread in our inmost being that we were going to meet our Waterloo then. Does it not seem to you, my busy sisters, that part of our duty is to help the student in the hospital school? Would it not be a wise thing for a successful private duty nurse to have a series of talks with the pupils on private duty nursing? Would it not seem only right that we should bring the weight of numbers and the wisdom of experience to the help of the superintendent and ask for better teaching and preparation for private duty to be given the pupils? A committee formed inside our private duty nursing section could, with advantage to all, work up such a plan which, tactfully presented, certainly should be warmly received by the superintendent of nurses and acted upon, if practical.

Pupil Nurses' Department

Student Nurses' Recreation

By R. LAYTON,
Vancouver General Hospital

"I used to spend a great deal of time on my music, but since I came in training I have not had time for it."

How many times have we heard just such a statement, or statements similar to this one!

Among the young women in our training schools for nurses are many who, previous to entering the school, were students of literature, music and art. When their duties as nurses began, other studies were discarded.

We must admit that a nurse's days are busy ones. When "coming off duty" at night, footsteps lagging, and mentally rehearsing the day's work—the sad parts, the bright "spots," the work we enjoyed and the work we did not enjoy—what does the nurse do, as a rule? Gathering her most intimate friends about her room, the entire party discuss the seriously ill patients on their respective wards, that "terrible" doctor, the "impossible" nurse, and so on. The same conversation may be heard in the nurses' dining-room, and at social gatherings where nurses are present.

The three years of training come to an end in a surprisingly short time. Following the never-to-be-forgotten graduation exercises, the nurse in training becomes the graduate nurse, of whom so much is expected, not only professionally but socially as well. Whether in private duty or in institutional work, the nurse who is well read and can converse intelligently upon general topics is infinitely more valuabie than one whose conversation is confined to "hospital" and "patients."

To use a common expression, let us avoid getting into a "rut," for we are prone to do just that. If we do not realize this while in training, we will when our training school days are at an end. The world has been moving during the three years of training, and, unless we keep in touch with what is happening, we will be left behind.

The question, then, is: How can we, as nurses in training, keep pace with the times and also avoid neglecting studies other than those connected with nursing?

First, the formation of a literary society would be of value. Instead of talking over our work, in the evenings, suppose we spend one or two evenings a week reading aloud from our favorite authors and discussing their works. Informal debates on topics of the day would serve to keep

us in touch with what is going on about us. A great deal might be done along musical lines as well, if we devoted at least one evening a week to music, instrumental and vocal. In other words, let us spend as much time as possible "keeping out of the rut," remembering that it is the responsibility of each one of us to make the best use of her time, whether "on duty" or "off duty." Time lost or wasted is the one thing which cannot be replaced.

Department of Nursing Education

Conducted by the Canadian Association of Nursing Education

University Credits

By Miss Raysile

Undoubtedly the nursing profession is on the threshold of a new day of opportunity of service, and, in order that nurses may fully meet this opportunity, the superior education provided by a university should be sought by nursing schools, just as eagerly as it is sought by all other types of professional schools.

In Canada, British Columbia has led the way, and already the Training School of the Vancouver General Hospital, which has this university connection, is attracting larger numbers of the better educated women who are so much needed everywhere in nursing to-day.

In the United States this same thing is found in the training schools that have this university connection, and nurses have shown themselves as keen in scholarship and as capable of meeting university standards as any other groups of students.

The latest development in university education for nurses is the five years, combined, liberal arts and professional programme, leading to the college degree and the professional diploma. The object of this combined programme is to give to the young high school graduate an opportunity to continue her general education in college for two years before taking up her hospital training, and to have the whole course knit together and carried on under the auspices of the university, and to ensure not only a broader cultural background for the nurse, but a sounder scientific foundation for her professional work.

In all universities the requirements for the Degree of Arts or Science is based on the credit system; so many credits or points. At McGill University 57 credits are required for a B.A. Degree, and these credits

are divided as follows throughout the four years: First year, six subjects, three hours weekly for college year, 18 credits; second year, five subjects, three hours weekly for college year, 15 credits; third year, four subjects, three hours weekly for college year, 12 credits; fourth year, four subjects, three hours weekly for college year, 12 credits. Total, 57.

The basis of credit for nursing courses would be exactly the same as for other college courses on condition that they measure up to the standards already outlined for college work. It is more difficult to find a basis of credit for the practical work of the hospital. No matter how valuable we may conceive this practical work to be, no college would allow any large proportion of its credits to be assigned to any high specialized form of technical work, whether it be music, or art, or physical training, or nursing.

In the above scale not more than 12 credits would be allowed for the practical work in nursing. This would be at the rate of about one-half a credit for each month, and we would have only 12 credits left to be divided among the various services.

Social Activities in Schools of Nurses

By Mary Martin

During the past few years one of the most discussed problems in nursing circles was the need for shorter hours for our student nurses. Not all our hospitals have as yet reached what we consider the ideal—an eight-hour day, but all have made some strides in that direction, and we feel it is only a matter of time and we shall see an eight-hour day in all hospitals, large and small, all over the country.

But if we have solved, or partly solved, the matter of shorter hours, we have brought ourselves face to face with another problem—not a new one, but rather another aspect of the same one—the need for more recreation, for more organized play for our student nurses.

Every child knows how to play; it is as natural as sleeping or breathing; but the wise parent suggests and supervises the child's play in order that it may accomplish the true purpose of all play—the satisfaction and the development of the individual. And our student nurses are, after all, only children grown—sometimes scarcely even that. They are none the worse for it, but rather the better, because they bring to this great profession of ours the freshness and the enthusiasm that belongs to youth alone—assets invaluable in our sick wards.

But because of their very youth we cannot afford to separate ourselves from their play, their various forms of recreation, without harmful results to them and to our training schools.

The word recreation comes from recreate, which means to renew, to give new life to, and has aptly been defined as anything which adds to the joy of living without detracting from the capacity for work. That gives us wide scope for activity; and the wider we make our recreational field, the more successful shall we be as training schools.

Time and again we hear the criticism that nurses are very one-sided; that they know little outside their own field of work, and with shame we have to confess that it is in a measure true, and that the fault is largely with our training schools. I think this criticism, more than any other, is responsible for our shortage of nurses, and only when we make our curriculum of education include the opportunities for that larger education outside the training school shall we be able to attract to our schools the type of young woman that we so earnestly desire.

Here, as in every other department of the hospital, the question of finance comes up. We cannot all spend the money to make our Nurses' Home the thing of beauty that we would like it to be, but it is amazing the changes that may be wrought with a few inexpensive yards of gay chintz, plus a can or two of paint.

Every Nurses' Home should possess a piano, and the nurses who are musically inclined encouraged to continue their studies. How often we hear the lament, "Oh, how I wish I could keep up my music, but since I came in training I haven't had a chance to practise." There is something wrong with our training schools if all the accomplishments, the hobbies which make life so much dearer to many of us, have to be completely forfeited during the three years of training.

Then nearly every school has one or two patrons who could be induced to contribute a few of the best magazines if this need was only placed before them. It is not sufficient to encourage our nurses to read the magazines that have to do with their work; it is equally important that they take an interest in the doings of the great world outside their training school. If the room can be possibly spared, it is a good plan to have a separate reading-room where silence is imposed.

It is always a wise policy to encourage the nurses to bring their friends into the home rather than to seek recreation away from it. Sometimes difficulty is experienced in trying to locate a nurse for a visitor, and often a vain search for 10 or 15 minutes only results in finding out that Miss So-and-So is on duty and cannot be seen. This difficulty can be partly overcome by placing a roster in the hall of the Nurses' Home. Each roster should consist of a board with a space allotted to each nurse, with a slip bearing her name, room number, and a peg hole, and at the lower end of the board a trough or box containing different colored pegs. There should be a printed slip explaining the peg system, say: Red, on duty; blue, off duty in the home; yellow, on vacation; white, on outside training; no peg, off duty and gone out.

If this simple device was adopted and the nurses forced to peg when passing through the hall, it would save a great deal of time and labor spent in an often futile search for a nurse, and at the same time save the visitors much inconvenience.

Schools unable to buy a tennis court or swimming tank for the use of their pupils can often secure these privileges by allying with some social club, such as the Y.W.C.A., or the C.G.I.T., one or both of which may be found in almost every small center. Most schools allow their nurses to hold frequent dances during the winter months, but many stop there. Why not encourage the nurses to form their own little clubs, to study drama, music, literature, etc.? It is amazing the amount of talent that exists among our young people, awaiting to be utilized. Encourage them to see the best plays, to take an interest in art exhibits, to attend public lectures. All of these carry not only social but educational advantages, and our nurses will be better nurses and better women in proportion as they are broad-minded.

—Read at the C.A.N.E. Convention, 1922.

The one outstanding error that has prevailed throughout the whole nursing system — and this school cannot be excepted — has been the assumption that overwork and severe discipline were necessary and even desirable concomitants of nurses in training. When it began to be understood that there was a difference between the self-imposed hardships and sacrifices of the religious orders and the preparation of modern young women for a profession, it was then impossible for economic reasons to lift the superfluous load that had broken the health of so many good women during the early days of training schools for nurses, when about only fifty per cent. of the pupils could, or would, stand the strain. The half century is closing without seeing a definite financial relief; nursing schools still remain under the shadow of an inherited system that is only beginning to be ameliorated. Saner policies claim for the workers a right to health, happiness and reasonable freedom. Nursing will always be a profession that requires voluntary self-sacrifice from those who have a "call" to this field of service. We begin to see, however, that self-abnegation must be voluntary and not imposed. To go on as in the past, almost entirely under the apprenticeship system, is impossible. The needs of the hospitals and the educational requirements of the students must be harmonized in those institutions that wish a high grade of nursing service.—"History of the Massachussetts General Hospital Training School," by Sara E. Parsons.

Hospitals and Nurses

QUEBEC

MONTREAL

The McGill University School for Graduate Nurses began its 1922-23 session on October 2nd, 1922. Eight regular full-time students registered in the Public Health Nursing course, and four in the course for Hospital Administration. Among the Canadian and American schools represented are the Royal Victoria and Montreal General, Calgary General, St. Vincent de Paul, Sherbrooke, St. Luke's Hospital, Ottawa General Public Hospital, St. John, Lowell, Mass., Rhode Island, and New England Hospital, Boston.

ROYAL VICTORIA HOSPITAL, MONTREAL

Miss M. A. Prescott (1905), superintendent of the Ross Memorial Pavilion, has left for an extended trip to Europe. During her absence Miss Ross (1919) will be in charge.

The annual Christmas dance, which is given by Sir Vincent Meredith, Bart., for the R.V.H. nurses, was held on the evening of December 18th in the Ritz-Carlton Hotel. The ballroom was gay with Christmas greens and holly, and the guests were received by Miss Hersey and Miss Guernsey.

Miss Alice Pickard (R.V.H., 1922) has accepted a position in the Yarmouth Hospital, Yarmouth, N. S.

Miss Eleanor O'Brien (R.V.H., 1918) is taking a course in X-ray under Dr. Pirie.

Miss Emma Steeves (R.V.H., 1921) has completed a course in public health nursing, and is now engaged in the work at Hanna, Sask.

Miss Lylas Cogland (R.V.H., 1921) has charge of the operating-room at the Drumheller Hospital, Drumheller, Alberta.

Miss Annie Bulman (R.V.H., 1919) and Miss Hesse Lapham (R.V.H., 1918) have gone to England to spend the winter with relatives.

The engagement is announced of Miss Florence Lockhart (R.V.H., 1919) to Mr. Philip Robertson, of Montreal, the marriage to take place in March. Miss Lockhart, until recently, has had charge of the operating-room of the Soldiers' Memorial Hospital at Campbelton, N. B. She will be succeeded by one of her own classmates, Miss Grace Thompson (R.V.H., 1919).

Miss Mollie Black (R.V.H., 1918) is in charge of a ward in the Ottawa Isolation Hospital.

Miss Anna Dickson (R.V.H., 1915) is taking a course in the Ottawa Isolation Hospital.

At the recent bazaar held at the Ritz-Carlton Hotel in aid of the fund for the nurses' club-house, the booth presided over by the Royal Victoria nurses brought in the splendid sum of over $2,000.00.

* * * *

ONTARIO

WELLESLEY HOSPITAL, TORONTO

The Alumnae dance held on November 24th proved very successful. The secretary was able to forward a cheque to the Northern Fire Relief Committee.

PETERBORO

The Alumnae Association of the Nicolls Hospital, Peterboro, was asked by the Memorial Committee for $216.00 as their share in the Ontario assessment. Through the efforts of the pupil nurses, with a garden party in August, the sum of $118.00 was raised, and the Alumnae held a most successful dance on November 10th, when $100.00 completed the sum required. The nurses feel indebted to the citizens of Peterboro for their whole-hearted support of this cause.

Sandwich

The Essex Tuberculosis Sanitarium at Sandwich, Ont., will be opened in February. Through the efforts of the I.O.D.E., $150,000.00 was collected, which built this ideal cottage hospital with accommodation for forty children and twenty adults. The administration building contains, as well, the quarters for nurses and household help.

Toronto Western Hospital A. A.

About 125 children were the merry guests of the Western Hospital on December 21st, when a Christmas dinner was served. Every child received a package containing "woollies' and other gifts to keep them warm during the coming winter. Santa Claus was assisted by Miss McKee, superintendent of nurses, and all declared it to be the most enjoyable entertainment the hospital had ever held.

Miss Edith McAlpine has joined the Rockefeller Institute for Research Work, and has gone to China.

Miss Milroy, who has been in the social service work for the Western Hospital for the past seven years, addressed the Alumnae Association this month on her work, which was much appreciated by the nurses. Miss Milroy has severed her connection with the hospital, to take up school nursing, and is succeeded by Miss Patterson.

Toronto General Hospital

Mrs. A. E. Bolton (T.G.H., 1891) has resigned her position as matron of the Children's Home in Hudson, N. Y., to accept the post of night supervisor at the Bronx Hospital, 169th Street, New York.

Misses Maisie Noble (1922) and Marguerite Hendrick (1922) have left to take up positions in the Union Hospital, Terre Haute, Ind., as instructress of nurses and supervisor of the surgical wards respectively.

Miss Shaffner (1922) has accepted the position of operating-room supervisor at the Hospital for Sick Children, Toronto.

Misses Irene Reid (1917), Edna McKinnon (1922) and Winnifred Allen (1922) have been appointed to the nursing staff of the diabetic clinic in the Pavilion, T.G.H.

Miss Grace Fuller is spending the winter in Florida. Mrs. Aubin is in charge of Queen's Park residence in her absence.

Miss Eleanor Hepburn (1922) has taken a position as assistant superintendent of the hospital at Elkhart, Indiana.

The patients of the Main building were entertained at a very delightful concert in the Outdoor Department, arranged by Mrs. Graham, of the Occupational Therapy Department. Tea was afterwards served to the entertainers in the nurses residence.

Dr. and Mrs. Herbert Bruce entertained the staff and students at a tea at their residence, "Annadale."

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SASKATCHEWAN

Saskatoon.

The Graduate Nurses' Association was well represented at the January meeting of the association, which was held in St. Paul s Hospital on Thursday evening, January 4th. Dr. H. Munroe's paper on "Radium' was listened to with the greatest interest, the senior nurses of the school also being in attendance for that part of the programme.

In addition to thirty dollars raised by a bridge party during the holiday season, the association voted an additional twenty dollars—this, along with a contribution of seventy dollars forwarded some time ago, bringing up the contributions from this association to the National Memorial Fund to one hundred and twenty dollars. Ten dollars was voted to the Red Cross, to assist with the splendid work being done in this province.

Miss E. M. Turner, R.N., superintendent of nurses in the Saskatoon City Hospital for the past two years, has resigned and left the city. Miss Turner has always taken a keen interest in local nursing affairs, as well as being active in nursing affairs of the province. She will be greatly missed by the nurses, as well as by the many friends she has made in the city.

Miss E. F. Macey, R.N., instructor of nurses in the City Hospital, has recently resigned, and is visiting friends in Winnipeg. It is understood that Miss Macey is to take charge of the Prince Albert Training School for Nurses. Miss Macey will be greatly missed in nursing centers in Saskatoon.

Miss S. Agnes Campbell, R.N. (Toronto General, 1912), who has been assistant superintendent of nurses, has received the appointment ot superintendent of the training school of the City Hospital.

Prince Albert

News of the resignation of Miss E. Eisele as superintendent of nurses of the Municipal Hospital, Prince Albert, has been received with great regret. Members of the local nurses' association will very much miss the guidance of their able president, and the training school has also lost a most efficient director.

Indian Head

Great regret is expressed at the resignation of Mrs. H. H. Campbell, the superintendent of the General Hospital. Mrs. Campbell leaves to take charge of a hospital in Augusta, Kansas. Miss Douglas, one of the graduates of the Indian Head Training School, has been appointed to succeed Mrs. Campbell.

* * * *

ALBERTA

Calgary.

A very enjoyable chicken dinner and dance was held on December 13th, when the committee, with Miss Cooper as convenor, won much praise. Over 150 guests were present. The usual business meeting was held on December 14th, with Mrs. A. H. Calder, vice-president, in the chair. Some amendments to the constitution, which have been under consideration, were adopted. The programme for the year was considered, which promises to be very interesting.

The January meeting was held on January 11th, Mrs. R. P. Stuart Brown, president, in the chair. It was decided that a dance be arranged for, to be held in February, Miss Cooper to be the convenor. The principal business of the meeting was the discussion of the proposal of the Local Council of Women to organize an order of "Housekeeping Nurses," who would be given a five months' course in an agricultural college, consisting of domestic science and home nursing. The concensus of opinion by the association was that patients in the country needed the services of the most highly skilled nurses as well as those living in the city, if not more, owing to the distance from the home of the medical men in the vicinity. It was decided to point out to the L.C.W. that the Provincial Public Health Department places a nurse in districts unable to support one, and the V.O.N. will send one if a board is properly organized and the demand for a nurse made, with a minimum salary of $125.00 guaranteed. Realizing the inability of many people to pay the fees of a graduate nurse, the hope was expressed that the day is not far distant when some community nursing scheme will be developed that all may be given skilled nursing service when needed. A resolution was sent in to the Local Council of Women asking that all matters pertaining to the nursing profession be first endorsed by the G. N. A., which is affiliated with the L. C. W., before being presented to the general meeting of the Local Council of Women.

* * * *

BRITISH COLUMBIA

Victoria

The efforts of the Graduate Nurses' Association of Victoria and the Alumnae of the Royal Jubilee Hospital, with their friends, have been successful in raising the quota assigned them of $500.00 for the Nurses' Memorial Fund.

Vancouver

The annual meeting of the G. N. A. of Vancouver was held on January 3rd, 1923, with good attendance. The election of officers was held and reports received from various committees. Miss Haskins, the retiring president, who

has held that office for four years, sent a letter of resignation, which was regretfully received. Miss Haskins is taking a course in public health nursing at the University of Washington. Miss A. McLellan was elected president, and Miss E. V. Cameron re-elected secretary.

The January general meeting of the G. N. A. of B. C. was held in Victoria on January 13th at the Royal Jubilee Hospital, following special meetings of the Council, the Nursing Education Committee, Private Duty Nursing and Public Health Nursing committees. The good attendance was encouraging. Reports of the committees (standing) were given at the general meeting, and a full and most interesting report of the Memorial Fund Committee was given by Miss Breeze, the convenor. A most important announcement was made that the University of British Columbia had acceded to the request from the G. N. A. of B. C., and, if sufficient students apply, will give a course for instructors, lasting six weeks, and a short intensive course for hospital administrators, lasting two weeks. These may also be taken as a combined course. This will be in progress at the same time as the summer school at the university. It was felt that this was the most important step the association had taken since the passing of the Registration Act and the inspection of training schools. The association expressed its gratitude to the university and to Miss Johns, who presented the request to the authorities at the university.

After the business of the meeting was concluded, the members listened to a most interesting address by Dr. Ernest Hall on Dr. Abram's "System of Diagnosis and Treatment." Refreshments were served by the Victoria Graduate Nurses' Association. Members from the mainland, the officers of the Victoria G. N. A., and the officers of the Jubilee Hospital Alumnae Association, as well as the staff of the hospital, were entertained at dinner at the Royal Jubilee Hospital.

Miss May McArthur, R.N., who has held the position of assistant to the director of nursing at the Vancouver General Hospital, has resigned to accept a similar position at the County Hospital, St. Paul, Minn.

New Westminster

Misses E. Taylor and E. Swanson (Royal Columbian Hospital, New Westminster) are taking post-graduate courses at the Cleveland Maternity Hospital.

Miss Marion Frame (Galt Hospital, Lethbridge) has taken a position at the Tranquille Sanitarium.

BIRTHS

Beaton—At Oshawa, Ont., on December 19th, 1922, to Mr. and Mrs. Beaton (Madeline Rogerson, Wellesley Hospital, Toronto, Ont., 1918), a daughter.

Burgess—At the Montreal Maternity Hospital, on January 3rd, 1923, to Dr. and Mrs. H. C. Burgess (Alice M. Eakin, Royal Victoria Hospital, Montreal, 1909), a son.

Campbell—At the Montreal Maternity Hospital, on January 1st, 1923, to Dr. and Mrs. Grant Campbell (Sophie Field, Royal Victoria Hospital, Montreal, 1910), a daughter.

Carr—At Hamilton, Ont., in December, 1922, to Dr. and Mrs. Leeming Carr (Betty McBeth, Toronto General Hospital, 1918), a daughter.

Donald—At the City Hospital, Saskatoon, Sask., on December 12th, 1922, to Mr. and Mrs. George M. Donald (Birdie Studdert, St. Mary's Hospital, Islington, London, England, 1909), a daughter.

Glass—At Kerrobert, on January 2nd, 1923, to Mr. and Mrs. Perry Glass (Elsa M. Stewart, Saskatoon City Hospital, 1917), a son.

Golden—At Wellesley Hospital, Toronto, Ont., on December 2nd, 1922, to Mr. and Mrs. A. Daunt Golden, a daughter.

McNair—At Peterboro, Ont., on November 24th, to Dr. and Mrs. McNair (Anna Stedham, Wellesley Hospital, Toronto, 1915), a daughter.

Miller—At Toronto, Ont., on October 12th, 1922, to Rev. J. A. and Mrs. Miller (Miss Jackson, Toronto Western Hospital, 1908), twin daughters.

Molyneux—In November, 1922, at Toronto, Ont., to Mr. and Mrs. Molyneux (Nursing Sister Gertrude Wright, Toronto Western Hospital, 1916), a son.

Simpson—At Collingwood, Ont., in December, 1922, to Dr. and Mrs. Thomas Simpson (Betty Peel, Toronto General Hospital, 1922), a son.

Smith—At Melford, Sask., on December 13th, 1922, to Mr. and Mrs. L. T. R. Smith (Eva M. Earl, R.N., Weyburn Municipal Hospital, 1918), a son (Lawrence Earl).

Withers—To Dr. and Mrs. H. F. Withers, Glenville, West Virginia (Janet Duff, General and Marine Hospital, St. Catharines, Ont., 1919), on November 17th, 1922, a daughter.

MARRIAGES

Bain-Wilcox—At Salmon Arm, B. C., on September 26th, 1922, Ida May Wilcox (Queen Victoria Hospital, Revelstoke, B. C.) to William A. Bain, of Grand Forks, B. C.

Bishop-Whiteford—At Summerland, B. C., on December 27th, 1922, Ethel May Whiteford (Royal Columbian Hospital, New Westminster, B. C.) to Mr. Alfred Bishop, of Vancouver. They will reside at 216 Thirteenth Avenue, West, Vancouver, B. C.

Carleton-Beatty—On September 27th, 1922, at North Bay, Ont., Elsie Beatty (Queen Victoria Memorial Hospital, 1922) to Mr. Rupert Carleton, both of North Bay, Ont.

Crewe-Edwards—On November 1st, 1922, at the Church of St. James the Apostle, Montreal, Que., by the Rev. Canon Shatford, Lillian Marguerite Edwards (Women's Hospital, Montreal, 1919) to Arthur Crewe, of Blackford, England.

Curtin-Thompson—At Vancouver, B. C., on December 26th, 1922, at Holy Rosary Rectory, Gladys Thompson (St. Paul's Hospital, Vancouver, B. C.), daughter of Dr. F. H. Thompson, of Hereford, England, to T. V. Curtin, M.D., of Vancouver, B. C.

Daniels-Greenway—On December 21st, 1922, Ila Greenway (Saskatoon City Hospital, 1917) to Mr. Arthur I. Daniels. Mr. and Mrs. Daniels will reside in Gadsten, Arizona.

Ellison-Harris—At Yuma, Arizona, on Sunday, December 31st, 1922, Dorothy Annie Harris (Saskatoon City Hospital, 1918) to Mr. William Luke Ellison.

Swan-Manchester—At the Dominion Methodist Church, Ottawa, Ont., on December 30th, 1922, Susan Aleda Manchester (Toronto General Hospital, 1920) to John E. Swan, of Toronto. At home, Pasadena, California.

DEATHS

Crewe—At the Montreal General Hospital, after a short illness, Arthur Crewe, of Blackford, England. Funeral services held December 11th, 1922. Interment at Blackford, England. Mrs. Crewe is Miss Lillian Edwards (Women's Hospital, Montreal, 1919).

Johnson—At the Royal Columbian Hospital, New Westminster, B. C., on January 12th, 1923, after a severe illness of nine months, Ethel Johnson (St. Boniface Hospital, St. Boniface, Man., 1918). Miss Johnson held positions on the staff of the Royal Columbian Hospital as surgical supervisor, night supervisor, and instructress of nurses.

Picken—In Vancouver, B. C., at 3570 Thirtieth Avenue, West, after a lingering illness, on January 13th, 1923, Elizabeth Picken (Winnipeg General Hospital), a native of Shropshire, England, and a resident of Vancouver for about twenty years.

Labor is rest from the sorrows that greet us; from all the petty vexations that meet us; from the sin-promptings that assail us; from the world sirens that lure us to ill.—F. S. ASGOOD.

He that is good may hope to become better; he that is bad may fear that he will become worse; for vice, virtue and time never stand still.—COLTON.

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REGISTRATION OF NURSES

The Province of Ontario has now in effect Rules and Regulations for the Registration of Nurses. A copy of these regulations, as well as application forms for registration, may be had by applying to Dr. Alex. MacKay, Inspector of Hospitals, Parliament Buildings, Toronto, Ont.

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"Canadian Nurse" Representative, Miss A. L. Burns, Moncton.

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Executive Committee—Miss May, Miss Lenfesty, Miss C. Kennedy, Miss Black, Miss Wilson. Refreshment Committee—Miss D. Binning, Miss Fellows.

Representative to the "Canadian Nurse"—Miss V. Horner.

Sick Visiting Committee—Miss G. Mayhew, Miss E. Jack.

Regular meeting first Monday at 8 p.m.

OFFICERS OF THE ALUMNAE ASSOCIATION OF THE SHERBROOKE HOSPITAL, SHERBROOKE, QUE.

President, Mrs. Wilfred Davey; First Vice-President, Mrs. C. K. Bartlett; Second Vice-President, Miss Buchanan; Recording Secretary, Miss Jessie Saint-Denis; Corresponding Secretary, Miss Van; Treasurer, Mrs. Colin Campbell; Representative to "Canadian Nurse," Mrs. Roy Wiggett, Apt. 17, Mon. Nationale, Sherbrooke; Regular Monthly Meeting—Second Tuesday.

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THE ALUMNAE ASSOCIATION OF THE WESTERN HOSPITAL, MONTREAL

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Convener of Finance Committee—Miss B. A. Birch, Western Hospital.
Convener of Programme Committee—Miss Ada Chisholm.
Convener of Membership and Visiting Committee—Miss Ethel Mount.
Convener of General Nursing Committee—Miss B. A. Birch.
Representative to Canadian Nurse—A. M. Stephens.

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Convenors of Committees—Finance, Miss Trench; Sick Visiting, Miss L. Drew, Miss Francis.

Representative to "Canadian Nurse", Miss S. Dewer, 786 Shuter St., Montreal.

Regular Monthly Meeting, third Wednesday at 8 p.m.

THE ALUMNÆ ASSOCIATION OF THE CHILDREN'S MEMORIAL HOSPITAL TRAINING SCHOOL FOR NURSES, MONTREAL

Hon. President, Miss Willoughby; President, Miss C. Macdonald; Vice-President, Miss Elsie Wood; Secretary Treasurer, Miss K. Maddocks.

Board of Directors—Miss Armour and Miss Morris.
Canadian Nurse Representative—Miss E. G. Miller.
Regular Meeting, First Friday of each month at 8.30 p. m.

THE ALUMNAE ASSOCIATION OF THE HOMEOPATHIC HOSPITAL. MONTREAL, QUE.

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Representative to the Canadian Nurse—E. Routhier, 4 Oldfield Ave.

Regular Monthly Meeting—First Thursday at 8 p.m.

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Babies	2 months
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Representative of the "Canadian Nurse" Magazine, Miss Agnes Jamieson, 975 Tupper Street, Montreal.

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Regular Meeting, First Tuesday, 8 p.m.

THE ALUMNAE ASSOCIATION OF THE ROYAL ALEXANDRA HOSPITAL, FERGUS, ONTARIO.

Honorary President, Mrs. Wickle, R.N., Fergus Hospital; President, Miss Helen Campbell, Woman's College Hospital, Toronto, Ont.; Vice-President, Miss Elizabeth Hansen, Christie Street Military Hospital, Toronto; Second Vice-President, Mrs. A. Hutchison, Fergus; Recording Secretary, Miss Marion Petty, Royal Alexandra Hospital, Fergus, Ontario; Corresponding Secretary, Miss Jean Derby, Victorian Order, 281 Sherbourne St., Toronto, Ont.; Treasurer, Miss Bertha Brillinger, 1725 Dufferin St., Toronto, Ont.

Press Representative—Miss Jean Campbell, 72 Hendrick Ave., Toronto, Ont.

Regular Meeting—First Monday of every month.

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Regular Meetings—The third Wednesday of each month in the Public Hospital.

GUELPH GENERAL HOSPITAL ALUMNAE ASSOCIATION.

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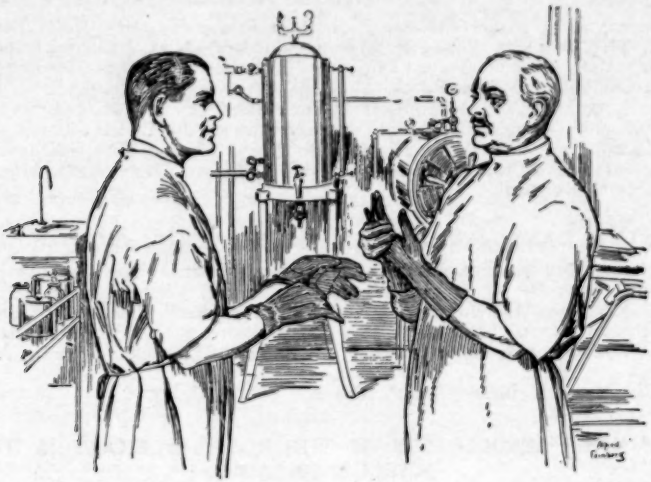
Representative to "Canadian Nurse'—Miss Eva Archer, Assistant Superintendent Nicholls' Hospital, Peterboro.



DR. JUNIOR: "Doctor, would you employ Antiphlogistine in severe cases—women, for instance—of abdominal pain, indicating possible ovaritis, peritonitis, salpyngitis, and so on?"

DR. SENIOR: "Why of course—at once, to relieve the distressing agony which often accompanies these female troubles."

DR. JUNIOR: "Well, I did that same thing, last night, and it was gratefully received by the patient. But—I had not studied 'Gynecology' that way——"

DR. SENIOR: "No, you felt, perhaps, that this was so simple a procedure that your prestige as a modern physician might be questioned—I know—I was once young and wished to appear 'ultra-scientific.'"

DR. JUNIOR: "Presume you're right. But—the patient says this morning, that she has had such attacks often, and never got out so easily or so quickly."

DR. SENIOR: "Such a procedure—that of applying Antiphlogistine to the abdomen in all incipient inflammations of that region, is as truly scientific as an operation, and sometimes makes that unnecessary. But its osmotic action, accompanied by initial heat (and generating its own 'chemical' heat, as we know it does), Antiphlogistine frequently aborts abdominal inflammations with speedy recovery and untold comfort to the sufferer."

DR. JUNIOR: "Really, Doctor—I believe Antiphlogistine has won me a friend, in this very instance."

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Representative to Local Council of Women—Miss Hewitt.

Representatives to Central Registry—Miss N. Lewis, Miss E. G. Woods.

Regular Meeting—Third Thursday, 4 p.m.

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Regular Meetings, First Friday of each month at 8 p.m.

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Meeting, Third Thursday at 8 p.m.

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(Incorporated 1918) Officers 1922-1923

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Incorporated 1908. Officers 1922-23

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Sick Visiting Committee—Misses H. Fagan and A. Brohman.

Representative to Central Registry—Miss T. Gurry.

Representative on "Canadian Nurse"—Miss E. Dermody, 157 Catherine St., South.

Regular Meeting—First Tuesday, 4 p.m.

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"Canadian Nurse" Correspondent—Miss R. Burnett, 25 Spadina Ave.

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Sick Committee—Miss A. P. Kerr, Miss M. E. Dunlop, Mrs. Reynolds, Miss R. Burnett, Miss Ainslie, Miss K. Peart.

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Canadian Nurse Representative—Miss Maysie Marriott.

Programme Committee—Misses Moyer, Freel, McGinnis, Rawlings, Buchanan and Honey

Regular Monthly Meeting—Last Tuesday, at 2:30 p.m.

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Regular Meeting—Second Wednesday, 8 p.m.

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Canadian Nurse Representative—Miss N. Casey, Chatham, Ontario.

Regular Meeting—First Monday, 3 p.m.

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Regular Meeting—Fourth Friday of each alternate month, at 8 p.m.

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Sick-Visiting Committee—Misses Cockburn, Sumner, Rinn and Grey.

Regular monthly meeting—First Tuesday, at 8 p. m.

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Regular Monthly Meeting—Second Monday, at 8 p.m.

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Regular Meetings—Second Friday of each alternate month.

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Regular Meeting—First Friday, 7.30 p.m.

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Incorporated March, 1917

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